Standardized

Credentialing

Form

To Be Used

By Health Maintenance Organizations

Licensed in the State of Missouri

REVISED VERSION EFFECTIVE FEBRURARY 2, 2OO1

COMPLETE EACH SECTION AS THOROUGHLY AS POSSIBLE. PLEASE TYPE OR PRINT

I. GENERAL INFORMATION

1. _____
   Name (Last, First, MI, Degree/Prof. Designation
   M.D./D.O./Ph.D./O.D./M.S.W./D.C./D.P.M./D.D.S./D.M.D./A.P.N./P.A./Other)

2. _____
   Home Address/Street

3. _____ 4. _____
   City/State/ZIP E-Mail Address

5. _____ 6. _____
   Other Names You May Have Used (i.e. Maiden, etc.) Date of Birth (Month/Day/Year)

7. _____ 8. _____
   Place of Birth Social Security Number

9. Are You a U.S. Citizen? Yes_____ No _____ 10. Sex: Male_____ Female_____

If Not a Citizen of the U.S., Indicate the Current Status of Your VISA:

_____

_____

_____

Form Authorized by the Missouri Department of Insurance 1998

DO NOT SUBMIT COMPLETED FORM TO THE DEPARTMENT OF INSURANCE

II. OFFICE/PRACTICE INFORMATION

If More Than Two Offices, Check Here ____ and Attach a Copy of Page 3, Completing Questions 22 - 40 for Each Office.

1. Participation Status For Which You Are Applying: (Indicate Specialty)

   Primary Care Specialty: _____ Subspecialty: _____ Patient Ages: _____

2. _____ From: _____
   PRIMARY OFFICE ADDRESS/STREET/BUILDING/SUITE (month/year)
3. _____
   City/State/ZIP
4. _____
   Tax ID # Owner/Corporate Name as Appears on SS4 or W-9 Form (or Full Legal Name)
5. _____
   Business Name or Name By Which the Provider Group is Generally Known
6. _____ 7. _____
   Office Phone Number After Hours/Emergency Number or Procedure
8. _____ 9. _____
   Office Fax Number Office E-Mail Address
10. _____ 11. _____
    Office Manager Federal Tax ID#
12. _____
    BILLING ADDRESS/STREET (If Different From Above)
13. _____
    Billing City/State/ZIP

14. List Routine Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday

15. Evening Hours: Yes_____ No_____ If Yes, List Hours After 5:00 P.M

Monday	Tuesday	Wednesday	Thursday	Friday

16. Weekend Hours: Yes_____ No_____

Saturday	Sunday

17(a) Lab Service in Your Office:
Yes_____ No_____

17(b) _____
If Yes, specify Waived, Physician Performed Microscopy, Moderately Complex, Highly Complex

18. Please check all of the following that you perform IN THIS OFFICE:
EKG ____ Office gynecology (Routine Pelvic/PAP) _____ Drawing Blood _____ Age appropriate immunizations _____
X-Rays ____ Minor Surgery ____ Tympanometry/audiometry screening _____ Flexible sigmoidoscopy _____
Laceration Repair ____ Pulmonary Function Studies _____ Asthma Treatment _____ Allergy Skin Testing _____
Osteopathic manipulation _____ IV hydration/treatment _____ Other (please specify) _____

19. (a) Languages Spoken (other than English): (b) Are Interpreters Available? Yes_____ No_____

_____ _____
Health Care Provider Staff

20. Does Your Office: *(CIRCLE ONE)*

(a) Have 24-Hr. Phone Coverage Service?	**Y**	**N**	(b) Qualify as a Minority Business Enterprise?	**Y**	**N**
(c) Have Capability for Electronic Billing?	**Y**	**N**	(d) Provide Child Care Services?	**Y**	**N**
(e) Meet ADA Accessibility Standards?	**Y**	**N**	(f) Have Public Transportation Accessibility?	**Y**	**N**
(g) Collaborate With an Advanced Nurse Practitioner or Physician Assistant (P.A.)?				**Y**	**N**

If Yes, Provide a Copy of Appropriate Collaborative Practice or P.A. Agreement(s) & the Name(s) of the Individual(s).

(h) Type of Practice: Solo Single Specialty Group Multispecialty Group Other
If Group Practice, Attach a List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.

21. Do You Currently: *(CIRCLE ONE)*

(a) Accept New Patients Into Practice?	**Y**	**N**	(b) Accept New Patients By Physician Referral Only?	**Y**	**N**
(c) Have Medicare Certification?	**Y**	**N**	(d) Accept Medicare Assignment?	**Y**	**N**
(e) Provide Inpatient Care?	**Y**	**N**	(f) Accept Medicaid Assignment?	**Y**	**N**

II. OFFICE/PRACTICE INFORMATION

If More Than Two Offices, Check Here ____ and Attach a Copy of Page 3, Completing Questions 22 - 40 for Each Office

22. Participation Status For Which You Are Applying: (Indicate Specialty)

Primary Care Specialty: _____ Subspecialty: _____ Patient Ages: _____

23. _____
SECONDARY OFFICE ADDRESS/STREET/BUILDING/SUITE

24. _____
City/State/ZIP

25. _____
Tax ID # Owner/Corporate Name as Appears on SS4 or W-9 Form (or Full Legal Name)

26. _____
Business Name or Name By Which the Provider Group is Generally Known

27. _____ 28. _____
Office Phone Number After Hours/Emergency Number or Procedure

29. _____ 30. _____
Office Fax Number Office E-Mail Address

31. _____ 32. _____
Office Manager Federal Tax ID#

33. _____
BILLING ADDRESS/STREET (If Different From Above)

34. _____
Billing City/State/ZIP

35. List Routine Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday

36. Evening Hours: Yes_____ No_____ If Yes, List Hours After 5:00 P.M.

Monday	Tuesday	Wednesday	Thursday	Friday

37. Weekend Hours: Yes_____ No_____

Saturday	Sunday

38.(a) Lab Service in Your Office:
Yes_____ No_____

38.(b) _____
If Yes, specify Waived, Physician Performed Microscopy, Moderately Complex, Highly Complex

39. Please check all of the following that you perform IN THIS OFFICE

EKG ____ Office gynecology (Routine Pelvic/PAP) _____ Drawing Blood _____ Age appropriate immunizations _____
X-Rays ____ Minor Surgery ____ Tympanometry/audiometry screening _____ Flexible sigmoidoscopy _____
Laceration Repair ____ Pulmonary Function Studies _____ Asthma Treatment _____ Allergy Skin Testing _____
Osteopathic manipulation _____ IV hydration/treatment _____ Other (please specify) _____

40. (a) Languages Spoken (other than English):

_____ _____
Health Care Provider Staff

(b) Are Interpreters Available? Yes_____ No_____

41. Does Your Office: *(CIRCLE ONE)*

(a) Have 24-Hr. Phone Coverage Service? **Y N** (b) Qualify as a Minority Business Enterprise? **Y N**
(c) Have Capability for Electronic Billing? **Y N** (d) Provide Child Care Services? **Y N**
(e) Meet ADA Accessibility Standards? **Y N** (f) Have Public Transportation Accessibility? **Y N**
(g) Collaborate With an Advanced Nurse Practitioner or Physician Assistant (P.A.)? **Y N**
If Yes, Provide a Copy of Appropriate Collaborative Practice or P.A. Agreement(s) & the Name(s) of the Individual(s).
(h) Type of Practice: Solo Single Specialty Group Multispecialty Group Other
If Group Practice, Attach a List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements

42. Do You Currently: *(CIRCLE ONE)*

(a) Accept New Patients Into Practice? **Y N** (b) Accept New Patients By Physician Referral Only? **Y N**
(c) Have Medicare Certification? **Y N** (d) Accept Medicare Assignment? **Y N**
(e) Provide Inpatient Care? **Y N** (f) Accept Medicaid Assignment? **Y N**

III A. PROFESSIONAL EDUCATION

List All Medical Schools/Institutions Attended.

Please Explain Any 30 Day or Greater Gap In Your Training. Attach Additional Sheets if Necessary.

1. _____
   Medical/Professional School Name
2. _____
   Address/Street
3. _____
   City/State/Zip/Country
4. From: _____ To: _____ 5. _____
   Dates Attended (month/year) Degree(s) Awarded
5. If You Are a Graduate of a Foreign Medical School, Are You Certified by the Education Council for Foreign Medical Graduates (ECFMG)? If Yes, Please Enclose a Copy of Your Certificate With This Application.
   Yes_____ No_____

III B. POSTGRADUATE TRAINING: INTERNSHIP

1. _____
   Institution Name
2. _____
   Address/Street
3. _____
   City/State/Zip
4. From: _____ To: _____ 5. _____
   Dates Attended (month/year) Department Chair/Program Director
5. _____
   Type of Internship (Rotating/Straight) - If Straight, Please List Specialty.

III C. POSTGRADUATE TRAINING: FIRST RESIDENCY

1. _____
   Institution Name
2. _____
   Address/Street
3. _____
   City/State/Zip
4. From: _____ To: _____ 5. _____
   Dates Attended (month/year) Department Chair/Program Director
5. _____
   Type of Residency

III D. POSTGRADUATE TRAINING: SECOND RESIDENCY or FELLOWSHIP

1. _____
   Institution Name
2. _____
   Address/Street
3. _____
   City/State/Zip
4. From: _____ To: _____ 5. _____
   Dates Attended (month/year) Department Chair/Program Director
5. _____
   Type of Residency/Fellowship

III E. POSTGRADUATE TRAINING: FELLOWSHIP/OTHER

1. _____
   Institution Name
2. _____
   Address/Street
3. _____
   City/State/Zip
4. From: _____ To: _____ 5. _____
   Dates Attended (month/year) Department Chair/Program Director
5. _____
   Type of Fellowship/Other Explanation

IV A. HOSPITAL AFFILIATIONS: PRIMARY

1. _____
   CURRENT PRIMARY HOSPITAL NAME
2. _____
   Address/Street
3. _____
   City/State/Zip
4. _____ 5. From: _____ To: _____
   Status of Privileges *(INDICATE BY USING KEY)* Dates Affiliated (month/year)

Status of Privileges Key

1 Active	4 Associate	7 Courtesy	10 Senior Staff	13 Consulting
2 Courtesy Provisional Staff	5 Visiting	8 Admitting	11 Provisional	14 Pending
3 Active Provisional Staff	6 Temporary	9 CO-Admitting	12 Suspended	15 Other:_____

If CO-Admitting Status, List Other Admitting Physician(s) _____

6. Any Past or Present Restriction of Privileges? Yes_____ No_____ *(IF YES, EXPLAIN)*

_____

IV B. HOSPITAL AFFILIATIONS: OTHER

List All Other Hospitals At Which You Have Or Have Had Privileges Attach Additional Pages If Necessary.

1a. _____
HOSPITAL NAME
2a. _____
Address/Street
3a. _____
City/State/Zip
4a. _____ 5a. From: _____ To: _____
Status of Privileges *(INDICATE BY USING KEY)* Dates Affiliated (month/year)
If CO-Admitting Status, List Other Admitting Physician(s) _____
6a. Any Past or Present Restriction of Privileges? Yes_____ No_____ *(IF YES, EXPLAIN)*

_____

1b. _____
HOSPITAL NAME
2b. _____
Address/Street
3b. _____
City/State/Zip
4b. _____ 5b. From: _____ To: _____
Status of Privileges *(INDICATE BY USING KEY)* Dates Affiliated (month/year)
If CO-Admitting Status, List Other Admitting Physician(s) _____
6b. Any Past or Present Restriction of Privileges? Yes_____ No_____ *(IF YES, EXPLAIN)*

_____

IV B. HOSPITAL AFFILIATIONS: OTHER (CONT'D)

1c. _____
HOSPITAL NAME

2c. _____
Address/Street

3c. _____
City/State/Zip

4c. _____ 5c. From: _____ To: _____
Status of Privileges *(INDICATE BY USING KEY)* Dates Affiliated (month/year)

If CO-Admitting Status, List Other Admitting Physician(s) _____

6c. Any Past or Present Restriction of Privileges? Yes_____ No_____ *(IF YES, EXPLAIN)*

_____

IV C. OTHER PRACTICE AFFILIATIONS (e.g. HMOs, PPOs, IPAs, PHOs, etc.)

Attach Additional Pages If Necessary

1a. _____
Institution/Organization Name

2a. _____
Address/Street

3a. _____
City/State/Zip

4a. _____ 5a. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1b. _____
Institution/Organization Name

2b. _____
Address/Street

3b. _____
City/State/Zip

4b. _____ 5b. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1c. _____
Institution/Organization Name

2c. _____
Address/Street

3c. _____
City/State/Zip

4c. _____ 5c. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1d. _____
Institution/Organization Name

2d. _____
Address/Street

3d. _____
City/State/Zip

4d. _____ 5d. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1e. _____
Institution/Organization Name

2e. _____
Address/Street

3e. _____
City/State/Zip

4e. _____ 5e. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

V. PRACTICE SPECIALTY

Attach Copy of Certificate(s). If Not Applicable to Your Profession/Specialty, Complete With N/

1. _____ 2. _____
PRIMARY SPECIALTY / BOARD CERTIFICATION Certification Numbe
3. _____ 4. _____
Name of Boarc Date of Certificatior
5. _____ 6. _____
Expiration Date Date of Recertification (If Applicable
7. _____
If Not Certified, Indicate Current Status and/or Date Intending to Sit For Board
8. _____ 9. _____
SECONDARY SPECIALTY / BOARD CERTIFICATION Certification Numbe
10. _____ 11. _____
Name of Boarc Date of Certificatior
12. _____ 13. _____
Expiration Date Date of Recertification (If Applicable
14. _____
If Not Certified, Indicate Current Status and/or Date Intending to Sit For Board

VI. WORK /PRACTICE HISTORY

List Chronologically All Employment, Including Self Employment, For the Last Ten (10) Years. For Any Gap in Chronolo
Explain On a Separate Sheet. Leave No Time Period Unaccounted For Within the Last Ten Years, Excluding Previou
Stated Training. Attach Additional Sheets If Necessary

1a. _____
NAME of PREVIOUS PRACTICE
2a. _____
Address/Street
3a. _____ 4a. _____
City/State/Zip Phone Numbe
5a. _____ 6a. From: To
Title or Professional Occupatior Dates of Employment (month/yea

1b. _____
NAME of PREVIOUS PRACTICE
2b. _____
Address/Street
3b. _____ 4b. _____
City/State/Zip Phone Numbe
5b. _____ 6b. From: To
Title or Professional Occupatior Dates of Employment (month/yea

1c. _____
NAME of PREVIOUS PRACTICE
2c. _____
Address/Street
3c. _____ 4c. _____
City/State/Zip Phone Numbe
5c. _____ 6c. From: To
Title or Professional Occupatior Dates of Employment (month/yea

1d. _____
NAME of PREVIOUS PRACTICE
2d. _____
Address/Street
3d. _____ 4d. _____
City/State/Zip Phone Numbe
5d. _____ 6d. From: To
Title or Professional Occupatior Dates of Employment (month/yea

VII. PROFESSIONAL CERTIFICATES / LICENSE NUMBERS

List All States In Which You Have Held, or Currently Hold a License to Practice Your Profession. Please Attach Copies.

1. _____ License/Certification/Registration Number; Licensing State
2. _____ Expiration Date
3. _____ Other License/Certification/Registration Number; Licensing State
4. _____ Expiration Date
5. _____ Other License/Certification/Registration Number; Licensing State
6. _____ Expiration Date
7. _____ Federal Drug Enforcement Agency (DEA) Number(s)
8. _____ Expiration Date(s)
9. _____ CDS Certification Number (BNDD Number for Missouri)
10. _____ Expiration Date
11. _____ Medicare/Unique Provide ID Number (UPIN)
12. _____ National Provider ID Number (NPI)
13. _____ State Medicaid Number(s); Licensing State(s)
14. _____ ECFMG Number

VIII. PROFESSIONAL LIABILITY INSURANCE INFORMATION

Please Attach a Copy of Your Current Certificate(s) or Declaration(s) of Insurance, Including HCSF for Kansas Practitioners.

1a. _____ **CURRENT CARRIER NAME**

2a. _____ Address/Street

3a. _____ City/State/Zip

4a. _____ Phone Number

5a. _____ Policy Number

6a. From: _____ To: _____ Dates of Coverage (month/year)

7. Indicate Coverage Type: Claims Based _____ Occurrence Based_____

8. Policy Limits: Per Occurrence $_____ Aggregate $_____

Prior Carriers Within the Last Ten (10) Years. Attach Additional Sheets if Necessary.

1b. _____ **PREVIOUS CARRIER NAME**

2b. _____ Address/Street

3b. _____ City/State/Zip

4b. _____ Phone Number

5b. _____ Policy Number

6b. From: _____ To: _____ Dates of Coverage (month/year)

1c. _____ **PREVIOUS CARRIER NAME**

2c. _____ Address/Street

3c. _____ City/State/Zip

4c. _____ Phone Number

5c. _____ Policy Number

6c. From: _____ To: _____ Dates of Coverage (month/year)

1d. _____ **PREVIOUS CARRIER NAME**

2d. _____ Address/Street

3d. _____ City/State/Zip

4d. _____ Phone Number

5d. _____ Policy Number

6d. From: _____ To: _____ Dates of Coverage (month/year)

IX. MALPRACTICE CLAIMS HISTORY

***A SIGNATURE IS REQUIRED AT THE BOTTOM OF THIS PAGE, EVEN IF THERE IS NO HISTORY TO REPORT**

Are you currently or have you within the last ten (10) years been involved in a malpractice suit or other suit or claim in which your care and treatment of a patient was at issue, including pending or dismissed cases or claims settled before or during trial, or settled to avoid a lawsuit? yes____ no____

If yes, answer the following questions for EACH such claim. Duplicate this page as necessary.

1. _____ Patient Name
2. _____ Plaintiff Name, If Other Than Patient
3. _____ Your Involvement in the Case (Attending, Consulting, Etc.)
4. _____ Date of Occurrence (month/day/year)
5. _____ Your Status in the Case (Primary Defendant, Co-Defendant, Other)
6. _____ Date Claim Was Filed (month/day/year)
7. _____ Professional Liability Insurance Carrier Involved
8. _____ Carrier's Phone Number
9. _____ Policy Number
10. _____ Additional Defendants
11. Describe the Allegations Against You: _____
12. Describe the Alleged Injury to the Patient: _____
13. Claimant/Plaintiff Filed Suit in Court? Yes_____ No_____
14. _____ State Court Case Number
15. _____ State
16. _____ County/Parish
17. _____ Federal Court (US District Court) Case Number
18. _____ District
19. Present Status of Claim: Open_____ Closed_____ Pending_____

If PENDING, DO NOT Complete the Rest of This Page*Except For Signature and Date*.

20. If Closed, Indicate the Method of Resolution:
    - Dismissed _____ Date: _____
    - Settled (With Prejudice) _____ Date: _____
    - Settled (Without Prejudice) _____ Date: _____
    - Judgment for Defendant(s) _____ Date: _____
    - Judgment for Plaintiff(s) _____ Date: _____
    - Other _____ Date: _____
21. _____ Settlement Amount Paid On Your Behalf (If Any)
22. Additional Information/Explanation:
    (e.g. Patient condition and diagnosis at time of incident, description of treatment, subsequent patient outcome, etc.)

_____ _____

Signature **Date (month/day/year)**

IF YOU HAVE NO HISTORY TO REPORT, PLEASE INDICATE THAT AND SIGN.

X. ADDITIONAL INFORMATION

Please Answer the Following Questions By Circling "Y" (Yes), "N" (No), or "N/A" (Not Applicable).

Please Provide an Explanation For Any "Yes" Responses on a Separate Page.

1. Have any of your board certifications ever been suspended, revoked, not renewed, denied renewal, voluntary or involuntarily surrendered?	Y	N	N/A
2. Have you ever been named as a defendant in any criminal case?	Y	N	N/A
3. Have you ever been convicted, pled guilty, or pled nolo contendere to any felony, any offense reasonably related to your qualifications, functions, or duties as a medical professional, or any offense an essential element of which is fraud, dishonesty, or an act of violence?	Y	N	N/A
4. Has your malpractice insurance ever been canceled, suspended, not renewed, special rated, or restricted by the exclusion of any specific procedures from coverage?	Y	N	N/A
5. Have you ever been denied participation, suspended from, or denied renewal from the Medicare or Medicaid program, or had participation status modified?	Y	N	N/A
6. Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent or stipulation order, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
7. Has your federal or state controlled substance license ever been suspended, revoked, voluntarily or involuntarily surrendered, restricted, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
8. Have your privileges at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, reduced, restricted, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
9. Within the last five years, have you ever been a participating provider of another HMO, PPO, PHO, or MSO, etc. with which you are not affiliated at this time?	Y	N	N/A
10. Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA, etc.)?	Y	N	N/A
11. Has any information on you ever been reported to the National Practitioner Data Bank?	Y	N	N/A
12. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application. Rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)	Y	N	N/A
13. Within the last five years, have you ever been reprimanded or disciplined in any manner by any state licensing authority or other professional board or peer review committee for conduct related to the use of alcohol or the use of any drug?	Y	N	N/A
14. Have you discontinued practice for any reason (other than for routine vacation) for one month (30 days) or more?	Y	N	N/A

X. ADDITIONAL INFORMATION (continued)

15. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies? Y N N/A

    If so, please provide the following information, attaching additional copies as necessary.

(a) _____ Organization Name

(b) _____ Type of Organizatior

(c) _____ Address/Street

(d) _____ City/State/Zip

(e) _____ Phone Number

(f) _____ Federal Tax ID#

(g) _____ Percent of Business Owned/Invested by Applicant

(h) _____ Nature of Business Interest (owner, partner, investor)

XI. ADDITIONAL DOCUMENTATION / ATTACHMENTS

Please Attach Copies of the Following Documents (If Applicable):

1. W9 Form For Each Entity the Applicant Expects Will Receive Payments or Reimbursement
2. Collaborative Practice and/or Physician Assistant Verification of Supervision Agreement(
3. A List of Other Members of Your Practice, Their Specialties, and Coverage Arrangemen
4. Education Council for Foreign Medical Graduates (ECFMG) Certificat
5. Board Certification Certificate(s)
6. Copies of Professional Diplomas, Internship, Residency, and Fellowship Certificates, As Applicab
7. Current State Licenses (For All States Practicing)
8. Federal DEA Certificate
9. State Controlled Substance Certificate(s) For All States Practicing (i.e. BNDD for Missour
10. Current Certificate(s) or Declaration(s) of Insurance, Including HCSF for Kansas Practitioner
11. Curriculum Vitae (If Required By Health Carrier)
12. Professional References (If Required By Health Carrier)
13. Signed Copy of an Affirmation and Release of Information Document (Attestation Page) As Stipulated By the Hea Carrier to Which the Applicant is Seeking to Become a Participating Provide
14. Attach a copy of all postgraduate (CME) activities which you have attended and for which you have received cr in the past 2 years
15. Include a list of societies of which you are currently a membe
16. Include copies of United States Military discharge papers/DD214 if discharged from U.S. Military, or status if currer serving.
17. Include a copy of certificate showing CLIA waiver number and identification numb
18. Provide a statement regarding the reasons for any inability to perform the essential functions, with or with accommodations, for the practice in which you are seeking to become a participating provic